Health Information Management
Department
St. John's Health
P.O. Box 428
Jackson, WY 83001
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# Authorization to Release Medical Information

**PATIENT INFORMATION (all must be completed):**
Name: _____ DOB: _____ Phone #: _____

Mailing Address: _____

*** Email: _____

1. INFORMATION RELEASED FROM:
__ HOSPITAL
__ PHYSICIAN OFFICE DR: _____

2. INFORMATION DISCLOSED TO:
Individual/Facility (name and address require below) or ___ SELF
_____ Phone # _____
Mailing Address
_____ Fax # _____
_____

3. **REQUIRED: Dates of Service (last 6 months if not specified) From: _____ To: _____ or_____ OPEN**

4. INFORMATION TO BE RELEASED:
___ Emergency Room Record ___ Lab/Blood/Pathology Reports ___ Radiology Images
___ Inpatient Record ___ Cardiopulmonary Records ___ Billing Records
___ Outpatient Record ___ Radiology Reports ___ Physician Office Notes
___ Other: _____ ___ All Records

5. PURPOSE OF DISCLOSURE:
___ Personal Record ___ Medical ___ Insurance ___ Legal ___ Other

6. DELIVERY METHOD (please initial)
___ Pick Up by Self or Designee _____ (ID required) ____ Mail ____ Fax
___ Email: _____

(Note the security of these transmissions cannot be controlled by SJH)

In the event the facility is unable to accommodate an electronic delivery as requested, an alternative delivery method will be provided (e.g., papery copy). There is a risk that a third party could see your PHI without your consent when receiving by fax or email. Your signature below releases St Johns Health from liability for unauthorized access to the PHI contained in this format or any risks (e.g, virus) introduced to your computer/device when receiving PHI in electronic format or by fax. Please Note: Your records may contain sensitive data including sensitive test results like HIV and STD. The information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer be protected under federal law. You have the right to revoke this authorization in writing to the address above. The revocation will not affect any actions taken in reliance on this authorization before the receipt of the written revocation.

SENSITIVE DATA: I understand that my medical records may contain information concerning my mental health and/or psychiatric treatment, and I authorize their release unless denied by my treating physician. _____ I Do Not Authorize Release

This Authorization will expire 1 year from now unless one of these is initialed: ___One time disclosure ___ No expiration

Signature _____ Date:_____